Formal and Informal Neighborhood Social Organization: Which Promotes Better Resident Health?

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Neighborhood social organization captures how neighborhood residents differently organize to exert social control and enact their vision of their community. Whereas structural aspects of neighborhoods have been found to predict the health of neighborhood residents, we know less about whether neighborhood social characteristics, like social organization, matter for resident health. In their study, authors tested whether two types of social organization—formal and informal—were more predictive of resident self-rated health in a diverse sample of Chicago residents. They used multilevel models with survey weights, ordered dependent variables, and multiple imputation. They found that one measure of formal social organization, organizational participation, was significantly associated with self-rated health even when controlling for other types of social organization and individual participation. The article concludes with a discussion of the implications for macro social work practice to address social determinants of health and improve community health.

KEY WORDS: *neighborhood effects; neighborhoods; self-rated health; social organization*

Residential neighborhoods have an effect on residents' health, according to increasing research in health and social sciences. This research finds that neighborhood structural characteristics are consistently associated with individual health outcomes. For example, living in disadvantaged neighborhoods is associated with poorer health (Robert, 1998) and an increased risk of developing chronic conditions such as hypertension (Kershaw et al., 2011). Similarly, neighborhood racial segregation is associated with poorer health for black residents (Subramanian, Acevedo-Garcia, & Osypuk, 2005). Studies of neighborhood socioeconomic characteristics and health often suggest that social characteristics of neighborhoods explain why neighborhood demographic composition contributes to resident health—a neighborhood's social character may cause health-harming stress or may provide health-supporting resources. Yet few studies actually examine whether neighborhood social characteristics contribute to health.

This study examines dimensions of one neighborhood social characteristic, social organization, which has been proposed as an important mechanism linking neighborhood structural characteristics to individual outcomes (Sampson, Morenoff, & Gannon-Rowley,

2002) such as health. Neighborhood social organization captures how neighborhoods differentially organize to exert social control over their community (Sampson & Graif, 2009). But most studies focus on the capacity of individuals in neighborhoods rather than the capacity of institutions (Sampson & Graif, 2009). Using a similar distinction, Swaroop and Morenoff (2006) described two categories of social organization: formal and informal. A neighborhood's formal social organization consists of the formal, established organizations that make up neighborhood civic life such as block groups, religious organizations, civic groups, and community organizations. Informal neighborhood social organization, on the other hand, captures the extent to which residents take problem-solving actions to address neighborhood issues such as talking to a politician and getting together with neighbors to take action. Both types of social organization capture the capacity of neighborhoods to realize community-level goals, addressing neighborhood problems and improving the quality of neighborhood life, which may in turn improve resident health. Social organization is particularly relevant to macro social workers because it presents a shorter-term, modifiable characteristic of neighborhoods that can be the focus of local intervention while addressing longer-term,

macroeconomic and political factors that create unequal neighborhoods.

Our research addressed whether both types of neighborhood social organization are related to better self-rated health. *Self-rated health* is a simple, commonly used, one-item measure of one's health. Despite its brevity, it consistently predicts clinical outcomes as well as mortality and morbidity (DeSalvo, Bloser, Reynolds, He, & Muntner, 2006; Fayers & Sprangers, 2002). Self-rated health has good test-retest reliability (Singh-Manoux et al., 2006) and is valid across social groups in the United States (Krause & Jay, 1994) and internationally (see, for example, Abdulrahim & El Asmar, 2012). Although incidence of a specific disease may suggest particular neighborhood-level exposures, self-rated health is well suited to understanding whether neighborhood social characteristics, such as social organization, matter for the overall health of residents. We tested which type of social organization—formal or informal—was more supportive of resident health. Then, we examined whether individual-level resident participation in neighborhood social organization explained neighborhood-level effects.

BACKGROUND

Understanding differences in formal and informal social organization in neighborhoods and their effects on resident health can inform theory-driven interventions that address social determinants of health (SDOH), an important area of health social work. Neighborhood social organization is a resource for residents that may protect against poorer health outcomes (Browning & Cagney, 2002). Whereas scholars have described the differences between formal and informal social organization (Sampson & Graif, 2009; Sampson et al., 2002), we found no studies that simultaneously examined the consequences of both formal and informal social organization for resident outcomes.

Formal Social Organization and Health

Social organization theory suggests that organizations, such as social services, have positive neighborhood externalities (Small, 2009), that is, benefits to the neighborhood as a whole as well as to neighborhood residents who do not use the services. Formal neighborhood social organization may therefore affect resident health through its contribution to neighborhood social control (Browning & Cagney, 2002), rather than through services provided to individuals.

Nevertheless, only one study (Subramanian, Kubzansky, Berkman, Fay, & Kawachi, 2006) examined whether the quantity of the neighborhood organizations predicts resident self-rated health and found that the predicted relationship contradicted social organization theory. This study of older adults examined whether the density of neighborhood services (that is, organizations per census tract population) that the authors argued promote social organization (for example, churches) was associated with self-rated health (Subramanian et al., 2006). Low density of social organization—promoting services was actually associated with lower likelihood of poor health. Nevertheless, more studies are needed to understand whether organizations have positive externalities that contribute to resident health, a question that our study seeks to address.

Another way in which researchers have operationalized formal neighborhood social organization is with aggregate, neighborhood-level measures of resident participation in community organizations, obtained from survey data (see, for example, Sampson & Graif, 2009). For example, Kim and Kawachi (2006) examined the effects of 40 large-scale communities in the United States on resident self-rated health ($N = 24,835$). Residents who lived in areas with higher participation in community organizations had better self-rated health when controlling for individual and neighborhood demographics and other community social characteristics. However, a longitudinal study in Great Britain ($N = 3,075$) found no significant association between community-level participation in organizations and resident self-rated health (Snelgrove, Pikhart, & Stafford, 2009). Both of these studies examined larger-scale communities; we found no studies that examined neighborhood-level participation in community organizations and self-rated health. Few studies have examined the relationship between formal social organization and health, though among them, there is little evidence of a relationship.

Informal Social Organization and Health

Informal social organization is more commonly researched in relation to health. It is argued that neighborhoods with high informal social organization will have residents who work together to address health needs of all residents, to make sure that the neighborhood has resources that support resident health, and to address neighborhood problems that would otherwise contribute to resident stress (Browning &

Cagney, 2002). Sampson, Raudenbush, and Earls (1997), in their work updating social organization theory, advanced one aspect of informal social organization, collective efficacy. Collective efficacy captures two components of the neighborhood: social cohesion and informal social control. *Collective efficacy* is therefore defined as mutual trust and solidarity among residents (that is, social cohesion) along with the shared expectation that neighbors will intervene for the common good of the neighborhood (that is, informal social control) (Sampson et al., 1997).

Although authors argued that informal social control in neighborhoods plays a role in the health of residents, previous studies have not consistently found a relationship between collective efficacy and self-rated health. One study tested whether neighborhood impoverishment affected self-rated health through collective efficacy but found no association between collective efficacy and self-rated health (Franzini, Caughy, Spears, & Esquer, 2005). In several studies in Chicago, researchers have modified Sampson and colleagues' (1997) measure of collective efficacy to health-related collective efficacy (Browning & Cagney, 2002, 2003; Cagney, Browning, & Wen, 2005). Two of these studies found that higher health-related collective efficacy was associated with better self-rated health (Browning & Cagney, 2002, 2003). However, health-related collective efficacy was not associated with individual self-rated health for a subsample of older adults (Cagney et al., 2005). Some research has found that one component of collective efficacy, social cohesion, and the related concept of social trust are associated with self-rated health (Kim, Subramanian, & Kawachi, 2006; Poortinga, Dunstan, & Fone, 2008; Subramanian, Kim, & Kawachi, 2002). The limited research on collective efficacy and self-rated health therefore suggests a null or positive relationship.

PURPOSE AND HYPOTHESES

We found no studies that compared the contributions of formal and informal social organization. Unpacking the contributions of each type of social organization may help inform neighborhood-level interventions for healthier communities. Formal neighborhood social organization may be especially important to transforming neighborhoods for resident health because formal social organization can be bolstered by outside resources. As formal social organization is an overlooked dimension of social organization research, we are particularly interested in whether it is more closely linked to resident health than informal

social organization. When we understand the type of social organization that most supports resident health, we can better intervene to address neighborhood-level SDOH. While addressing neighborhood poverty and disadvantage may be long-term goals, policy and practice in neighborhoods can more immediately address neighborhood social organization if, indeed, there is evidence that it improves resident health.

This research sought to understand whether informal and formal neighborhood social organization predicts resident self-rated health. The following four hypotheses guided our study: (1) Greater neighborhood formal social organization is associated with better resident self-rated health. (2) Greater neighborhood informal social organization is associated with better resident self-rated health. Because measures of formal social organization are not as well established as measures of informal social organization, we also controlled for individual-level participation to improve our understanding of whether the processes that support resident health occur at the neighborhood level. This hypothesis suggests that it is not selection bias (that is, residents who participate are healthier therefore the neighborhood-level participation appears to support resident health), but a neighborhood-level social process. (3) Greater neighborhood formal social organization is associated with better self-rated health when controlling for individual participation in community organizations. We also hypothesized that formal social organization would be more predictive of self-rated health. (4) Greater neighborhood formal social organization is more strongly associated with better self-rated health than informal social organization is.

METHOD

This study used data from the Chicago Community Adult Health Study (CCAHS), which surveyed 3,105 adults from a neighborhood-stratified, multistage probability sample of Chicago residents (Morenoff et al., 2007). Interviewers administered face-to-face surveys with one adult from each sampled household between 2001 and 2003. The response rate was 72 percent. Interviewers asked about respondents' physical and mental health, activities, and neighborhood perceptions. The CCAHS defined neighborhoods as neighborhood clusters ($N = 343$), which were composed of contiguous census tracts, following the Project on Human Development in Chicago Neighborhoods (Sampson et al., 1997).

This study also used organizational data from InfoUSA, a commercial business database that CCAHS

researchers purchased, cleaned, and verified. The data consist of both nonprofit and for-profit businesses with Chicago addresses in November 2002. The data include North American Industry Classification System (NAICS) codes, which classify organizations by type of industry. CCAHS researchers have used InfoUSA data to understand the presence of specific resources in neighborhoods (see, for example, Bader, Ailshire, Morenoff, & House, 2010).

Measures

Dependent Variable. Respondent self-rated health was assessed with the single question, “All in all, would you say that your health is generally excellent, very good, good, fair, or poor?” Although some researchers dichotomize this measure, we maintained the ordinal level of measurement, with higher scores indicating better health.

Neighborhood-Level Independent Variables. Two variables capture formal social organization. The first was neighborhood organizational resources, which came from InfoUSA data. The variable was the square root of the rate of child and other social services organizations per 10,000 residents in a neighborhood cluster. These organizations were those in a neighborhood with a NAICS code for child and youth services, other individual and family services, community and food services, temporary shelters, or child day care services. Because the rate of organizations was highly skewed, we used a square root transformation. Finally, we standardized this variable at the neighborhood level with a mean of 0 and standard deviation of 1 to facilitate comparison of neighborhood-level measures.

The second measure of formal social organization was neighborhood organizational participation. It was composed of the sum of six respondent-reported indicator items of participation in service or civic organizations, religious groups, block or community groups, neighborhood watch, local action group, or ethnic or civil rights groups. This measure was standardized and aggregated to the neighborhood level using empirical Bayes (EB) estimation (Mujahid, Diez Roux, Morenoff, & Raghunathan, 2007) to create neighborhood-level estimates closer to the grand mean. In the final analysis, we standardized this variable with a mean of 0 and standard deviation of 1.

We assessed informal social organization with collective efficacy (Sampson et al., 1997), which is a 10-item scale comprised of two component scales:

social cohesion and social control. The social cohesion scale consisted of five items about neighbors’ willingness to help each other and shared values, with response options ranging from 1 = disagree strongly to 4 = agree strongly. The social control scale included five items about neighbors’ actions, with response options ranging from 1 = very unlikely to 4 = very likely. Individual scores (the average of all items with responses) were aggregated to the neighborhood level using EB estimation and then standardized with a mean of 0 and standard deviation of 1.

Individual-Level Control Variables. We measured education with a four-category variable: less than 12 years, 12 years, 13 to 15 years, or 16 or more years. Employment status was split into three categories: currently employed, not employed (which included looking for work, retired, or keeping house), and student. Income was a continuous measure of annual household income. Due to the large portion of respondents with missing data ($n = 501$), CCAHS researchers multiply imputed five iterations of income, which we use in this analysis. Marital status was a three-category variable: married, previously married (which included those who reported being separated, divorced, or widowed), and never married. Age was a continuous variable. Age squared captures the curvilinear relationship of age to participation and was first mean-centered to avoid collinearity. Interviewers recorded observed gender as female or male. The race and ethnicity variable reflects answers to two questions: Respondents were first asked to report whether they identify as Hispanic or Latino, and then what race they identify as. The Latino category was comprised of Hispanics or Latinos of any race. White included respondents who identified as white or Caucasian and not Latino; African American included those who identified as black or African American and not Latino. All others, if not also Hispanic or Latino, were grouped into the “other” category due to small sample sizes. First-generation immigrant comes from a survey question about place of birth. Interviewers recorded the language of the interview (English, Polish, or Spanish), and we recoded this into an indicator variable of “not in English.” The dichotomous activism variable indicated participation in either or both “a community project” and “any group that took local action for reform” within the last 12 months.

Analysis

We used multilevel modeling to examine the relationship between neighborhood organizational

resources and self-rated health. Multilevel models were necessary because neighborhood-level data violate the independence assumption. Analysis was conducted using HLM 7 (Raudenbush, Bryk, & Congdon, 2013) because it could accommodate survey weights, ordered dependent variables, and multiple imputation. We used survey weights to account for the complex sampling design (see Morenoff et al., 2007). We modeled self-rated health as an ordered variable. HLM fits multilevel proportional odds models with cumulative odds for ordinal dependent variables. In the cumulative odds model, odds represent the probability of being at or below a given threshold of the ordinal variable (O’Connell, 2010). This produces somewhat counterintuitive odds ratios (ORs). That is, ORs greater than 1 represent greater odds of being at or below fair health and therefore a lower chance of having better health. Models were estimated with random intercepts but not random slopes.

FINDINGS

Table 1 displays descriptive statistics for CCAHS respondents and the weighted sample used in analyses. Most respondents reported very good health (36 percent of the weighted sample), with over half reporting very good or better health. Respondents were diverse in their race and ethnicity as well as socioeconomic characteristics.

Table 2 displays the multiply imputed multilevel ordered logit models predicting self-rated health. Model 1 presents the results of a model testing the first measure of formal neighborhood social organization, organizational resources, along with individual demographic controls. Organizational resources were not significantly associated with self-rated health. Individual characteristics associated with self-rated health included education, employment, age, race and ethnicity, and responding in a language other than English.

Model 2 displays the test of the second measure of formal social organization, organizational participation. Organizational participation was significantly associated with lower odds of being at or below each level of self-rated health, meaning that those in neighborhoods with more organizational participation have better self-rated health compared with those in neighborhoods with average organizational participation. Relationships remained consistent between individual-level characteristics and self-rated health. Taken together, models 1 and 2 demonstrate only

Table 1: Individual-Level Descriptive Statistics (N = 3,105)		
Characteristic	n	%
Self-rated health		
Poor	94	2.89
Fair	453	12.72
Good	979	29.52
Very good	1,036	36.42
Excellent	543	18.45
Education		
Less than 12 years	792	23.42
12 years	759	23.75
13–15 years	817	24.95
16+ years	737	27.90
Employment status		
Employed	1,954	64.36
Not employed	1,056	32.28
Student	95	3.36
Marital status		
Married	1,091	41.81
Previously married	841	21.52
Never married	1,173	36.69
Female	1,870	52.62
Race and ethnicity		
Non-Hispanic white	983	38.36
Hispanic	802	25.81
Non-Hispanic black	1,240	32.07
Other	80	3.77
First-generation immigrant	773	26.89
Not in English	464	15.16
Activism	599	19.26
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Income in dollars (nonimputed)		50,460.00
Income in dollars (imputed)		48,778.52
Age (years)		42.47

Notes: Sample size is given for unweighted sample; percentages and means are weighted.

mixed support for hypothesis 1. Model 3 tested the measure of informal social organization, collective efficacy. Collective efficacy was associated with lower odds of being at or below each level of self-rated health, supporting hypothesis 2. One standard deviation increase in collective efficacy was associated with .90 odds lower likelihood of being at or below each level of self-rated health. This effect was slightly smaller than the OR for organizational participation (OR = .86, *p* < .01). Model 4 included these two variables together and found that only organization participation remained significant.

Model 5 tested the effects of formal and informal social organization while also controlling for individual-level participation in neighborhood activism. This measure of individual participation did not alter the model, suggesting that the neighborhood-level

Table 2: Multilevel Ordered Logit Models Predicting Self-Rated Health (*N* = 3,105)

	Model 1 OR (95% CI)	Model 2 OR (95% CI)	Model 3 OR (95% CI)	Model 4 OR (95% CI)	Model 5 OR (95% CI)
Individual level					
Education (ref: 16+ years)	2.73 (2.07, 3.59)***	2.64 (2.01, 3.46)***	2.71 (2.06, 3.58)***	2.64 (2.01, 3.47)***	2.62 (2.00, 3.44)***
Less than 12 years	1.99 (1.54, 2.57)***	1.94 (1.51, 2.49)***	1.99 (1.54, 2.57)***	1.94 (1.51, 2.50)***	1.93 (1.51, 2.48)***
12 years	1.68 (1.34, 2.12)***	1.66 (1.33, 2.08)***	1.69 (1.35, 2.13)***	1.67 (1.33, 2.09)***	1.67 (1.33, 2.08)***
13-15 years					
Employment (ref: employed)	1.67 (1.35, 2.06)***	1.67 (1.35, 2.06)***	1.66 (1.34, 2.05)***	1.67 (1.35, 2.05)***	1.66 (1.35, 2.05)***
Not employed	0.94 (0.62, 1.45)	0.98 (0.64, 1.52)	0.96 (0.62, 1.47)	0.99 (0.64, 1.52)	0.99 (0.64, 1.53)
Student	1.00 (1.00, 1.00)	1.00 (1.00, 1.00)	1.00 (1.00, 1.00)	1.00 (1.00, 1.00)	1.00 (1.00, 1.00)
Income					
Marital status (ref: married)	1.20 (0.95, 1.53)	1.19 (0.94, 1.51)	1.18 (0.93, 1.49)	1.18 (0.93, 1.49)	1.18 (0.93, 1.49)
Previously married	1.14 (0.89, 1.45)	1.13 (0.89, 1.44)	1.12 (0.87, 1.43)	1.12 (0.88, 1.43)	1.12 (0.88, 1.43)
Never married	1.02 (1.02, 1.03)***	1.02 (1.02, 1.03)***	1.02 (1.02, 1.03)***	1.02 (1.02, 1.03)***	1.03 (1.02, 1.03)***
Age	1.00 (1.00, 1.00)***	1.00 (1.00, 1.00)***	1.00 (1.00, 1.00)***	1.00 (1.00, 1.00)***	1.00 (1.00, 1.00)***
Age squared	1.16 (0.98, 1.39)	1.17 (0.98, 1.39)	1.17 (0.98, 1.40)	1.17 (0.99, 1.40)	1.17 (0.99, 1.40)
Female					
Race and ethnicity (ref: white)	1.34 (1.04, 1.72)*	1.33 (1.04, 1.71)*	1.32 (1.03, 1.70)*	1.32 (1.02, 1.69)*	1.32 (1.03, 1.70)*
Hispanic	1.57 (1.28, 1.93)***	1.70 (1.37, 2.11)***	1.50 (1.22, 1.85)***	1.63 (1.29, 2.05)***	1.62 (1.2, 2.04)***
Non-Hispanic black	1.21 (0.69, 2.13)	1.23 (0.70, 2.17)	1.19 (0.67, 2.10)	1.21 (0.68, 2.15)	1.21 (0.68, 2.15)
Other non-Hispanic	1.05 (0.78, 1.40)	1.03 (0.77, 1.38)	1.04 (0.78, 1.39)	1.03 (0.77, 1.37)	1.02 (0.77, 1.36)
First gen. immigrant	1.56 (1.12, 2.16)**	1.52 (1.09, 2.11)**	1.55 (1.12, 2.15)**	1.52 (1.09, 2.11)**	1.52 (1.09, 2.11)**
Not in English					0.95 (0.77, 1.18)
Activism					
Neighborhood level					
Organizational resources	1.01 (0.94, 1.08)	0.86 (0.78, 0.96)**		0.88 (0.78, 0.99)*	0.88 (0.79, 0.99)*
Organization participation				0.93 (0.85, 1.02)	0.93 (0.85, 1.02)
Collective efficacy				0.00 (0.00, 0.01)***	0.00 (0.00, 0.01)***
Intercept	0.00 (0.00, 0.01)***	0.00 (0.00, 0.01)***	0.00 (0.00, 0.01)***	0.00 (0.00, 0.01)***	0.00 (0.00, 0.01)***
	SD (Variance)	SD (Variance)	SD (Variance)	SD (Variance)	SD (Variance)
Random effects	0.31 (0.10)	0.29 (0.08)	0.30 (0.09)	0.28 (0.08)	0.28 (0.08)

Notes: OR = odds ratio; CI = confidence interval; ref = reference group.
*p < .05. **p < .01. ***p < .001.

processes cannot be explained by individual residents' participation in their neighborhood, which supports hypothesis 3. Rather, formal neighborhood social organization, as measured by organizational participation, remained a significant predictor of self-rated health; higher neighborhood organizational participation was associated with a lower likelihood of being at or below each level of self-rated health. Models 4 and 5 support hypothesis 4 for the organizational participation measure of formal social organization.

DISCUSSION

Our research tested whether formal and informal social organization in residential neighborhoods contribute to self-rated health and found that formal social organization, as measured by neighborhood-level organizational participation, was most consistently associated with self-rated health. Formal social organization continued to predict better self-rated health when controlling for individual participation. Findings from this study support Small's (2009) assertion that organizations have positive neighborhood externalities. This research has implications for policy and practice to improve neighborhoods and resident health.

Findings from this research can inform health social work, especially practice that addresses SDOH. Health social workers can improve the health of individuals in their community by intervening at the macro level to increase neighborhood social organization, in particular formal social organization that engages residents. Community-level interventions that build the capacity of organizations have the potential to improve resident health if they include residents as members and active participants. Such "place-based" initiatives call for a community development approach wherein neighborhood residents address challenges within their neighborhood. Alternatively, formal neighborhood social organization may be addressed through a "place-conscious" approach, which recognizes that many of the resources necessary for improving neighborhoods exist outside rather than within the neighborhood (Turner, Edelman, Poethig, & Aron, 2014). This approach recognizes that inequality in neighborhood resources stems from policy and market forces at higher levels of government and scales of community. Therefore, practice and policy that address these systemic inequalities, more distal social determinants, may better support more organizations, which in turn might lead to more organizational involvement.

Readers should consider the strengths and limitations of the present study when evaluating the findings. The cross-sectional data limit causal inference. Although the neighborhood and individual diversity of the CCAHS sample is a strength, the inability to generalize beyond Chicago is a limitation. The CCAHS data represents Chicago in the early 2000s, but few data sets offer these resident and neighborhood measures because the collection and maintenance of such data is time and resource intensive, making it a unique resource for researchers. This study, like most neighborhood-effects research, is limited in its reliance on administrative boundaries, which may not reflect residents' experience (Coulton, Jennings, & Chan, 2013). These artificial boundaries may contribute to our finding that one measure of formal social organization (that is, organizational resources) was not related to self-rated health while the other was. Future research should examine formal social organization with spatial relationships to organizational resources. Alternatively, although measuring formal social organization is an important contribution of this study, the measures are not ideal. For example, InfoUSA data do not capture the extent to which organizations are community involved. In addition, it may have systematic biases in its population of organizations. Researchers should develop improved measures for assessing neighborhood formal social organization to improve our understanding of the neighborhood social environment.

This study advances neighborhood effects research by explicating the links between neighborhood context and individual health outcomes. Future research should continue to examine how these different aspects of neighborhood social organization contribute to both physical and mental health. Longitudinal research on these relationships would be especially important to understand the extent to which neighborhood interventions might improve resident health and well-being. More specifically, research on community development and community planning interventions that seek to strengthen formal social organization, and especially resident participation in organizations, may be especially important for improving our understanding of how neighborhoods matter for residents. **HSW**

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